

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041434</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Lyncrest Manor of Effingham</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>1610 North Lakewood</u> <u>Effingham</u> <u>62401</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Effingham</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(217) 247-7470</u> Fax # <u>(217) 342-2731</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____																									
IDPA ID Number: <u>371346156003</u>		(Print Name and Title) _____ <u>Altschuler, Melvoin & Glasser LLP</u> (Firm Name One South Wacker Drive & Address) <u>Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>																									
Date of Initial License for Current Owners: <u>04/01/96</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> "Sub-S" Corp.																										
	<input checked="" type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Michael Kaplan</u> Telephone Number: <u>312-634-3400</u> <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u>																											

Please send copies of any desk review or audit adjustments to the above address.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Effingham# 0041434 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds n/a

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>80</u>	Skilled (SNF)	<u>80</u>	<u>29,280</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,280</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,027</u>	<u>1,027</u>	8
9	SNF/PED					9
10	ICF	<u>7,881</u>	<u>7,828</u>		<u>15,709</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,881</u>	<u>7,828</u>	<u>1,027</u>	<u>16,736</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 57.16%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/01/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 02/01/98NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 8 and days of care provided 1,027Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lyncrest Manor of Effingham # 0041434 Report Period Beginning: 01/01/00 Ending: 12/31/00**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	98,992	5,967	5,123	110,082		110,082		110,082		1
2	Food Purchase		63,867		63,867		63,867	(2,440)	61,427		2
3	Housekeeping	41,422	5,015	153	46,590		46,590		46,590		3
4	Laundry	38,971	9,690	967	49,628		49,628		49,628		4
5	Heat and Other Utilities			43,074	43,074		43,074	123	43,197		5
6	Maintenance	16,265		20,063	36,328		36,328	159	36,487		6
7	Other (specify):*										7
8	TOTAL General Services	195,650	84,539	69,380	349,569		349,569	(2,158)	347,411		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	493,961	34,641	1,424	530,026		530,026		530,026		10
10a	Therapy			97,184	97,184		97,184		97,184		10a
11	Activities	27,740	3,398	1,990	33,128		33,128		33,128		11
12	Social Services	17,583		1,718	19,301		19,301		19,301		12
13	Nurse Aide Training	8		832	840		840		840		13
14	Program Transportation			143	143		143		143		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	539,292	38,039	109,891	687,222		687,222		687,222		16
	C. General Administration										
17	Administrative	54,141		36,622	90,763		90,763	(36,622)	54,141		17
18	Directors Fees										18
19	Professional Services			22,886	22,886		22,886	2,234	25,120		19
20	Dues, Fees, Subscriptions & Promotions			11,055	11,055		11,055	(276)	10,779		20
21	Clerical & General Office Expenses	60,342	21,768	21,810	103,920		103,920	2,708	106,628		21
22	Employee Benefits & Payroll Taxes			110,529	110,529		110,529	3,351	113,880		22
23	Inservice Training & Education			1,005	1,005		1,005	1,107	2,112		23
24	Travel and Seminar			3,175	3,175		3,175	747	3,922		24
25	Other Admin. Staff Transportation			3,067	3,067		3,067		3,067		25
26	Insurance-Prop.Liab.Malpractice			28,129	28,129		28,129	40	28,169		26
27	Other (specify):*										27
28	TOTAL General Administration	114,483	21,768	238,278	374,529		374,529	(26,711)	347,818		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	849,425	144,346	417,549	1,411,320		1,411,320	(28,869)	1,382,451		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Lynncrest Manor of Effingham #0041434 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			50,207	50,207		50,207	284	50,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,797	122,797		122,797	1,466	124,263			32
33	Real Estate Taxes			16,233	16,233		16,233		16,233			33
34	Rent-Facility & Grounds							1,608	1,608			34
35	Rent-Equipment & Vehicles			2,135	2,135		2,135	566	2,701			35
36	Other (specify):*											36
37	TOTAL Ownership			191,372	191,372		191,372	3,924	195,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,699	3,789	24,488		24,488		24,488			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,920	43,920		43,920		43,920			42
43	Other (specify):* Nonallowable costs			74,838	74,838		74,838	(74,838)				43
44	TOTAL Special Cost Centers		20,699	122,547	143,246		143,246	(74,838)	68,408			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	849,425	165,045	731,468	1,745,938		1,745,938	(99,783)	1,646,155			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Effingham

0041434

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,821)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,704)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(454)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(961)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,851)	43		18
19	Entertainment				19
20	Contributions	(426)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(515)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,966)	43		24
25	Fund Raising, Advertising and Promotional	(4,793)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(137)	43		28
29	Other-Attach Schedule See Schedule 5A	(919)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,547)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(21,236)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,236)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (99,783)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

IDA

001434

Report Period Beginning:

01/01/00

Ending:

12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Vending machine income offset	\$ (619)	1
2	Chamber of Commerce dues disallowed	(300)	20
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
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82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(919)	90

Facility Name & ID Number Lyncrest Manor of Effingham# 0041434

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DSI Partners, L.L.C	100.00%	Lyncrest Manor of Aledo	Aledo, Illinois	DSI Management		
(owned 55% by Jerry Neal, and		Lyncrest Manor of Auburn	Auburn, Illinois	Services, Inc.	Peoria, IL	Management Co.
15% each by Sherry Borum-Neal,		Lyncrest Manor of Paris	Paris, Illinois	DSI Partners of		
Lester Robertson, and Ronald				Ohio, L.L.C	Peoria, IL	Management Co.
Mangum)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$	DSI Management Services, Inc.	A	\$ 123	\$ 123	1
2	V	6	Maintenance		DSI Management Services, Inc.	A	159	159	2
3	V	17	Management Fees	36,622	DSI Management Services, Inc.	A		(36,622)	3
4	V	19	Professional Services		DSI Management Services, Inc.	A	2,749	2,749	4
5	V	20	Fees, Subscriptions, & Promotions		DSI Management Services, Inc.	A	24	24	5
6	V	21	Clerical & General Office Exp.		DSI Management Services, Inc.	A	2,708	2,708	6
7	V	22	Employee Benefits		DSI Management Services, Inc.	A	3,351	3,351	7
8	V	23	Inservices Training & Education		DSI Management Services, Inc.	A	1,107	1,107	8
9	V	24	Travel & Seminar		DSI Management Services, Inc.	A	747	747	9
10	V	26	Insurance-Prop. Liab. Malpractice		DSI Management Services, Inc.	A	40	40	10
11	V	30	Depreciation		DSI Management Services, Inc.	A	284	284	11
12	V	32	Interest		DSI Management Services, Inc.	A	1,920	1,920	12
13	V	34	Rent-Facility & Grounds		DSI Management Services, Inc.	A	1,608	1,608	13
14	Total			\$ 36,622			\$ 14,820	\$ * (21,802)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT A: Owned 100% by Jerry Neal

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.
 ☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	35 Rent-Equipment & Vehicles	\$	DSI Management Services, Inc.	A	\$ 566	\$ 566	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 566	\$ *	566 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT A: Owned 100% by Jerry Neal

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Lyncrest Manor of Effingham # 0041434 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lester Robertson	Executive VP	Administrative	15.00%	77,457	5.15	13%	Salary	\$ 11,986	L17,C1	1
2											2
3											3
4											4
5											5
6											6
7					See attached Schedule 7A						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,986		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Effingham# 0041434

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DSI Management Services, Inc.Street Address 4239 War Memorial DriveCity / State / Zip Code Peoria, IL 61614Phone Number (309) 685-0595Fax Number (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Beds	597	8	\$ 920	\$	80	\$ 123	1
2	6	Maintenance	Beds	597	8	1,187		80	159	2
3	19	Professional Services	Beds	597	8	20,515		80	2,749	3
4	20	Fees, Subscriptions, & Promotions	Beds	597	8	181		80	24	4
5	21	Clerical & General Office Exp.	Beds	597	8	20,209		80	2,708	5
6	22	Employee Benefits	Beds	597	8	25,009		80	3,351	6
7	23	Inservices Training & Education	Beds	597	8	8,260		80	1,107	7
8	24	Travel & Seminar	Beds	597	8	5,578		80	747	8
9	26	Insurance-Prop. Liab. Malpractice	Beds	597	8	298		80	40	9
10	30	Depreciation	Beds	597	8	2,116		80	284	10
11	32	Interest	Beds	597	8	14,327		80	1,920	11
12	34	Rent-Facility and Grounds	Beds	597	8	12,002		80	1,608	12
13	35	Rent-Equipment & Vehicles	Beds	597	8	4,225		80	566	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 114,827	\$		\$ 15,386	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Carol Fleming		x	Mortgage	\$17,230.00	02/02/98	\$ 1,360,000	\$ 1,088,891	01/02/08	0.0900	\$ 109,603	1	
2	NCS Lease		x	Hardware/Software	\$314.00	10/31/98	18,845	11,781	09/30/03	0.1429	763	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$17,544.00		\$ 1,378,845	\$ 1,100,672			\$ 110,366	9	
	B. Non-Facility Related*												
10								Allocated from DSI Partners, L.L.C.			11,740	10	
11								Allocated from Management Company			1,920	11	
12								Miscellaneous Interest Expense			691	12	
13								Interest Income Offset			(454)	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 13,897	14	
15	TOTALS (line 9+line14)						\$ 1,378,845	\$ 1,100,672			\$ 124,263	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lyncrest Manor of Effingham**# **0041434** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	32,025	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	\$	24,149	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(7,876)	3	
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	24,109	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5	
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	16,233	7	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995		8
	1996	20,624	9
	1997	31,657	10
	1998	32,025	11
	1999	24,149	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Real estate tax accrual is based on 100% of prior year's tax.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:
21,644

B. General Construction Type:

Exterior
Brick

Frame
Brick

Number of Stories
1

C. Does the Operating Entity?

☒ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:
N/A

2. Number of Years Over Which it is Being Amortized:
N/A

3. Current Period Amortization:
N/A

4. Dates Incurred:
N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	176,400	1998	\$ 32,600	1
2					2
3	TOTALS	176,400		\$ 32,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1998	1998	\$ 1,183,400	\$ 29,585	40	\$ 29,585		\$ 83,824	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			1996	800	80	10	80		310	9
10	Floor Drains			1997	3,808	254	15	254		974	10
11	Room Remodeling			1999	3,889	260	15	260		476	11
12	Draperies			1999	3,216	214	15	214		393	12
13	Water Heater			2000	2,450	61	10	61		61	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 1,197,563	\$ 30,454		\$ 30,454		\$ 86,038	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 180,420	\$ 19,017	\$ 19,017	\$	5-10	\$ 50,829	37
38	Current Year Purchases	7,800	736	736		8-10	736	38
39	Fully Depreciated Assets							39
40	Allocated from Management Company			284	284			40
41	TOTALS	\$ 188,220	\$ 19,753	\$ 20,037	\$ 284		\$ 51,565	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,418,383	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 50,207	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 50,491	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 284	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 137,603	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				1,608			6
7	TOTAL				\$ 1,608			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease n/a.

None

n/a

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,701 Description: Copier-\$466; Postage Machine-\$769; Dishwasher \$900; Allocated from Management Company \$566

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>8</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u> </u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	832	\$	832
2	Books and Supplies				
3	Classroom Wages (a)		8		8
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	840	\$	840
10	SUM OF line 9, col. 1 and 2 (e)	\$	840		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a,C3	hrs	\$	426	\$ 25,090	\$	426	\$ 25,090	1
2	Licensed Speech and Language Development Therapist	L10a,C3	hrs		228	6,689		228	6,689	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a,C3	hrs		1,275	65,405		1,275	65,405	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				20,699		20,699	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A					3,596			3,596	13
14	TOTAL			\$	1,929	\$ 100,780	\$ 20,699	1,929	\$ 121,479	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Laboratory	L39,C3		\$		\$ 1,145			\$ 1,145	1
2	Urology	L39,C3				496			496	2
3	Ostomy	L39,C3				271			271	3
4	Ambulance	L39,C3				434			434	4
5	Special Services	L39, C3				1,095			1,095	5
6	Xray	L39,C3				155			155	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14	TOTAL			\$		\$ 3,596	\$		\$ 3,596	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 236,277	\$ 236,277	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 64,375)	228,666	228,666	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,350	49,350	6
7	Other Prepaid Expenses	9,904	9,904	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Parties	205,629	205,629	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 729,826	\$ 729,826	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,600	32,600	13
14	Buildings, at Historical Cost	1,197,563	1,197,563	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	188,220	188,220	16
17	Accumulated Depreciation (book methods)	(137,603)	(137,603)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,280,780	\$ 1,280,780	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,010,606	\$ 2,010,606	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 262,258	\$ 262,258	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,099	53,099	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,076	4,076	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,109	24,109	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	1,631,506	1,631,506	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,975,048	\$ 1,975,048	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,781	11,781	39
40	Mortgage Payable	1,088,891	1,088,891	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,100,672	\$ 1,100,672	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,075,720	\$ 3,075,720	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,065,114)	\$ (1,065,114)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,010,606	\$ 2,010,606	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (849,786)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (849,787)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(215,327)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (215,327)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,065,114)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,394,826	1
2	Discounts and Allowances for all Levels	(90,411)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,304,415	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	177,384	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 177,384	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	86	13
14	Non-Patient Meals	1,821	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,718	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,065	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 47,739	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	454	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 454	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	619	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 619	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,530,611	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	349,569	31
32	Health Care	687,222	32
33	General Administration	374,529	33
B. Capital Expense			
34	Ownership	191,372	34
C. Ancillary Expense			
35	Special Cost Centers	99,326	35
36	Provider Participation Fee	43,920	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,745,938	40
41	Income before Income Taxes (line 30 minus line 40)**	(215,327)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (215,327)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files as part of a combined cash basis return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lyncrest Manor of Effingham# 0041434Report Period Beginning: 01/01/00Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,929	2,033	\$ 34,484	\$ 16.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,892	4,307	68,571	15.92	3
4	Licensed Practical Nurses	7,005	8,006	94,445	11.80	4
5	Nurse Aides & Orderlies	25,454	27,797	230,610	8.30	5
6	Nurse Aide Trainees	1	1	8	8.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,819	2,137	18,475	8.65	8
9	Activity Director					9
10	Activity Assistants	3,930	4,266	27,740	6.50	10
11	Social Service Workers	2,023	2,114	17,583	8.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,724	13,763	98,992	7.19	15
16	Dishwashers					16
17	Maintenance Workers	1,781	1,797	16,265	9.05	17
18	Housekeepers	5,816	6,179	41,422	6.70	18
19	Laundry	5,126	5,688	38,971	6.85	19
20	Administrator	1,907	2,060	42,155	20.46	20
21	Assistant Administrator					21
22	Other Administrative	268	279	11,986	42.96	22
23	Office Manager					23
24	Clerical	3,777	3,936	60,342	15.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,651	1,786	15,280	8.56	31
32	Other Health Care: See Schedule 20A	1,984	2,171	32,096	14.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,087	88,320	\$ 849,425 *	\$ 9.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 4,288	L1,C3	35
36	Medical Director	monthly	6,600	L9,C3	36
37	Medical Records Consultant	monthly	1,260	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	164	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,292	L11,C3	44
45	Social Service Consultant	34	1,718	L12,C3	45
46	Other(specify) <u>Lab Consultant</u>	monthly	193	L39,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	156	\$ 15,515		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Carl Eibes	Administrator	0.00%	\$ 42,155	Workers' Compensation Insurance	\$ 20,336	IDPH License Fee	\$ 400				
Lester Robertson	Administrative	15.00%	11,986	Unemployment Compensation Insurance	12,626	Advertising: Employee Recruitment	5,048				
				FICA Taxes	60,845	Health Care Worker Background Check					
				Employee Health Insurance	14,588	(Indicate # of checks performed 101)	707				
				Employee Meals		Illinois Health Care Association	3,767				
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Nursing Home Association					
				Other Employee Benefits	2,134	Misc. Dues & Subscriptions	833				
				Allocated from Management Company	3,351	Allocated from Management Company	24				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 54,141							
B. Administrative - Other											
Description				Amount							
Management Fees (eliminated in Column 7)				\$ 36,622							
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 36,622	TOTAL (agree to Schedule V, line 22, col.8) \$ 113,880						
(Attach a copy of any management service agreement)					E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount					Description	Amount			
Altschuler,Melvoin & Glasser LLP	Accounting	\$ 8,006		n/a		\$	Out-of-State Travel	\$			
Mangum,Smietanka & Johnson	Legal	871									
ADP	Payroll Service	4,093									
AHCA	Computer Services	1,275					In-State Travel	1,915			
AIMS	Computer Services	2,525									
NCS Lease	Computer Services	2,845									
Personnel Planners	U/C Consulting	600									
Therapeak	Therapy Services	1,385					Seminar Expense	1,260			
Health Outcomes	Computer Services	360					Allocated from Management Company	747			
American Express Tax & Bus Svc	Accounting	926									
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		Entertainment Expense	(
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)				
\$ 22,886							TOTAL	\$ 3,922			

* Attach copy of IMRF notifications

****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	n/a												
3													
4													
5													
6													
7													
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12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Effingham

STATE OF ILLINOIS

0041434

Report Period Beginning:

01/01/00

Ending:

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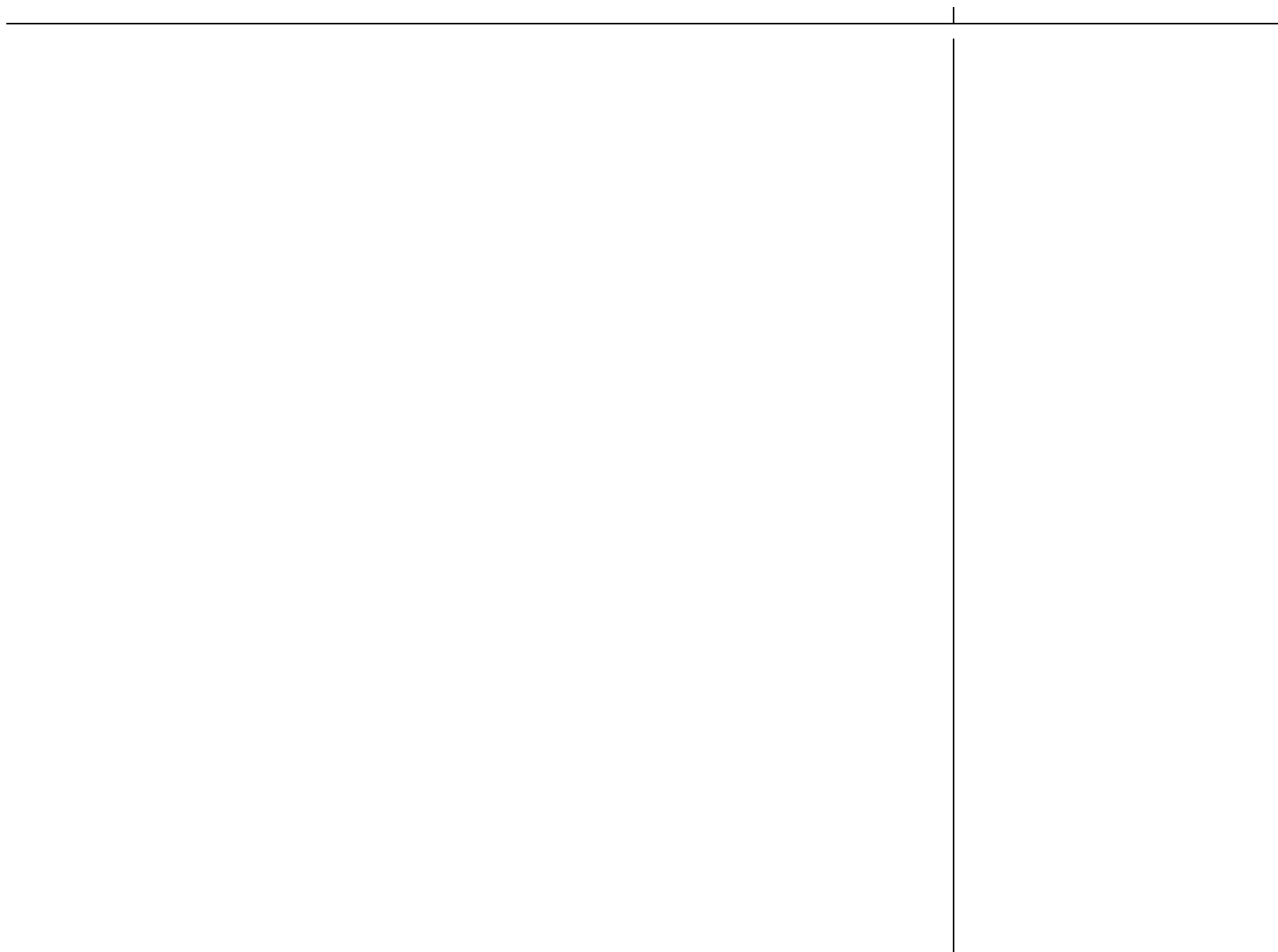
12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$3,767
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 9 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,978 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 43,920
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,821
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? 4%
d. Have vehicle usage logs been maintained? Adequate records are maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.



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